		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041459

Facility Name: Lynncrest Manor of Auburn

Address: 304 Maple Avenue (Number) Auburn (City) 62615 (Zip Code)

County: Sangamon

Telephone Number: (217) 438-6125 **Fax #** (217) 438-6316

IDPA ID Number: 371346156002

Date of Initial License for Current Owners: 4/1/96

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[x]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[x]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Michael Kaplan Telephone Number: (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			640	640	8
9	SNF/PED					9
10	ICF	13,843	8,644		22,487	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,843	8,644	640	23,127	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.52%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 6 and days of care provided 640

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	91,467	7,111	6,430	105,008		105,008		105,008			1
2	Food Purchase		90,240		90,240		90,240	(4,613)	85,627			2
3	Housekeeping	41,903	6,604		48,507		48,507		48,507			3
4	Laundry	24,174	6,192		30,366		30,366		30,366			4
5	Heat and Other Utilities			58,261	58,261		58,261	34	58,295			5
6	Maintenance	32,064		17,902	49,966		49,966	241	50,207			6
7	Other (specify):*											7
8	**TOTAL General Services**	189,608	110,147	82,593	382,348		382,348	(4,338)	378,010			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	637,363	33,694	5,459	676,516		676,516		676,516			10
10a	Therapy			82,238	82,238		82,238		82,238			10a
11	Activities	28,397	2,781	1,906	33,084		33,084		33,084			11
12	Social Services	12,951		1,905	14,856		14,856		14,856			12
13	Nurse Aide Training											13
14	Program Transportation			129	129		129		129			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	678,711	36,475	97,637	812,823		812,823		812,823			16
	C. General Administration											
17	Administrative	64,017		15,806	79,823		79,823	(15,806)	64,017			17
18	Directors Fees											18
19	Professional Services			21,032	21,032		21,032	1,582	22,614			19
20	Dues, Fees, Subscriptions & Promotions			7,236	7,236		7,236	55	7,291			20
21	Clerical & General Office Expenses	83,306	26,263	18,847	128,416		128,416	5,313	133,729			21
22	Employee Benefits & Payroll Taxes			144,026	144,026		144,026	4,843	148,869			22
23	Inservice Training & Education							502	502			23
24	Travel and Seminar			1,930	1,930		1,930	1,078	3,008			24
25	Other Admin. Staff Transportation			2,115	2,115		2,115		2,115			25
26	Insurance-Prop.Liab.Malpractice			30,439	30,439		30,439	61	30,500			26
27	Other (specify):*											27
28	**TOTAL General Administration**	147,323	26,263	241,431	415,017		415,017	(2,372)	412,645			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,015,642	172,885	421,661	1,610,188		1,610,188	(6,710)	1,603,478			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lynncrest Manor of Auburn #0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
30	Depreciation			6,682	6,682		6,682	388	7,070			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,325	128,325		128,325	2,187	130,512			32
33	Real Estate Taxes			12,652	12,652		12,652		12,652			33
34	Rent-Facility & Grounds			197,952	197,952		197,952	2,307	200,259			34
35	Rent-Equipment & Vehicles			2,575	2,575		2,575	1,215	3,790			35
36	Other (specify):*											36
37	**TOTAL Ownership**			348,186	348,186		348,186	6,097	354,283			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,151	2,005	10,156		10,156		10,156			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,325	38,325		38,325		38,325			42
43	Other (specify):* **Nonallowable costs**			16,557	16,557		16,557	(16,557)				43
44	**TOTAL Special Cost Centers**		8,151	56,887	65,038		65,038	(16,557)	48,481			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,015,642	181,036	826,734	2,023,412		2,023,412	(17,170)	2,006,242			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,613)	2		4
5	Telephone, TV & Radio in Resident Rooms	(426)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(13)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(465)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(11,310)	43		18
19	Entertainment				19
20	Contributions	(361)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,127)	43		24
25	Fund Raising, Advertising and Promotional	(830)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,038)	43		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (21,183)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	4,013		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 4,013		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (17,170)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lynncrest Manor of Auburn

ID# 0041459

Report Period Beginning: 1/1/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,613)	0	0	0	0	0	0	0	0	0	0	(4,613)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	34	0	0	0	0	0	0	0	0	0	34	5
6	Maintenance	0	241	0	0	0	0	0	0	0	0	0	241	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,613)	275	0	0	0	0	0	0	0	0	0	(4,338)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(15,806)	0	0	0	0	0	0	0	0	0	(15,806)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,582	0	0	0	0	0	0	0	0	0	1,582	19
20	Fees, Subscriptions & Promotions	0	55	0	0	0	0	0	0	0	0	0	55	20
21	Clerical & General Office Expenses	0	5,313	0	0	0	0	0	0	0	0	0	5,313	21
22	Employee Benefits & Payroll Taxes	0	4,843	0	0	0	0	0	0	0	0	0	4,843	22
23	Inservice Training & Education	0	502	0	0	0	0	0	0	0	0	0	502	23
24	Travel and Seminar	0	1,078	0	0	0	0	0	0	0	0	0	1,078	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	61	0	0	0	0	0	0	0	0	0	61	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(2,372)	0	0	0	0	0	0	0	0	0	(2,372)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,613)	(2,097)	0	0	0	0	0	0	0	0	0	(6,710)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lynncrest Manor of Auburn **#** 0041459 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	388	0	0	0	0	0	0	0	0	0	388	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13)	2,200	0	0	0	0	0	0	0	0	0	2,187	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,307	0	0	0	0	0	0	0	0	2,307	34
35	Rent-Equipment & Vehicles	0	0	1,215	0	0	0	0	0	0	0	0	1,215	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13)	2,588	3,522	0	0	0	0	0	0	0	0	6,097	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(16,557)	0	0	0	0	0	0	0	0	0	0	(16,557)	43
44	**TOTAL Special Cost Centers**	(16,557)	0	0	0	0	0	0	0	0	0	0	(16,557)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(21,183)	491	3,522	0	0	0	0	0	0	0	0	(17,170)	45

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DSI Partners, L.L.C.	100.00%	Lynncrest Manor of Aledo	Aledo	DSI Management		
(owned 55% by Jerry Neal, and		Lynncrest Manor of Effingham	Effingham	Services, Inc.	Peoria	Management Co.
15% each by Sherry Borum-Neal,		Lynncrest Manor of Paris	Paris	DSI Partners of		
Lester Robertson (sold his interest,				Ohio, L.L.C.	Peoria	Management Co.
Dec. 2001), Ronald Mangum)						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	DSI Management Services, Inc.	A	$ 34	$ 34	1
2	V	6	Maintenance		DSI Management Services, Inc.	A	241	241	2
3	V	17	Management Fees	15,806	DSI Management Services, Inc.	A		(15,806)	3
4	V	19	Professional Services		DSI Management Services, Inc.	A	1,582	1,582	4
5	V	20	Dues & Subscriptions		DSI Management Services, Inc.	A	55	55	5
6	V	21	Clerical & General Office Exp.		DSI Management Services, Inc.	A	5,313	5,313	6
7	V	22	Employee Benefits		DSI Management Services, Inc.	A	4,843	4,843	7
8	V	23	Inservices Training & Education		DSI Management Services, Inc.	A	502	502	8
9	V	24	Travel & Seminar		DSI Management Services, Inc.	A	1,078	1,078	9
10	V	26	Insurance		DSI Management Services, Inc.	A	61	61	10
11	V	30	Depreciation		DSI Management Services, Inc.	A	388	388	11
12	V	32	Interest		DSI Management Services, Inc.	A	2,200	2,200	12
13	V					A: Owned 100% by Jerry Neal			13
14	Total			$ 15,806			$ 16,297	$ * 491	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent-Facility & Grounds	$	DSI Management Services, Inc.	A	$ 2,307	$ 2,307	15
16	V	35	Rent-Equipment & Vehicles		DSI Management Services, Inc.	A	1,215	1,215	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V					A: Owned 100% by Jerry Neal			38
39	Total			$			$ 3,522	$ * 3,522	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Lester Robertson	Executive VP	Administrative	15.00	67,159	7	18.00	Salary	$ 15,068	L17, C1	1
2											2
3											3
4											4
5			See attached Schedule 7A								5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 15,068		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

DSI Management Services, Inc.
Administrative Salaries/Hours Allocation
12/31/01

Schedule 7A

VII. RELATED PARTIES (continued)
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.
Compensation Received From Other Nursing Homes

Name	Lynncrest Manor of Aledo	Lynncrest Manor of Auburn	Lynncrest Manor of Effingham	Lynncrest Manor of Paris	Out of State Facilities	Total
Lester Robertson	21,525	15,068	17,220	13,346	15,068	82,227

See Accountants' Compilation Report

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DSI Management Services, Inc.
Street Address: 4239 War Memorial Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Beds	382	7	$ 183	$	70	$ 34	1
2	6	Maintenance	Beds	382	7	1,314		70	241	2
3	19	Professional Services	Beds	382	7	8,631		70	1,582	3
4	20	Dues & Subscriptions	Beds	382	7	298		70	55	4
5	21	Clerical & General Office Exp.	Beds	382	7	28,995		70	5,313	5
6	22	Employee Benefits	Beds	382	7	26,429		70	4,843	6
7	23	Inservices Training & Education	Beds	382	7	2,738		70	502	7
8	24	Travel & Seminar	Beds	382	7	5,882		70	1,078	8
9	26	Insurance	Beds	382	7	331		70	61	9
10	30	Depreciation	Beds	382	7	2,116		70	388	10
11	32	Interest	Beds	382	7	12,006		70	2,200	11
12	34	Rent-Facility and Grounds	Beds	382	7	12,590		70	2,307	12
13	35	Rent-Equipment & Vehicles	Beds	382	7	6,630		70	1,215	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 108,143	$		$ 19,819	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Carol Van Dyke-Fleming		X	Lease Purchase	$6,650.00	02/02/98	$ 525,000	$ 406,914	02/02/08	0.0900	$ 31,669	1
2	NCS Lease		X	Hardware/Software	$446.00	10/31/98	27,952	20,156	09/30/03	0.1429	1,550	2
3	Sterling Health Care		X	Furniture	$576.00	12/07/01	6,906	6,434	12/07/02	0.1797	29	3
4												4
5												5
	Working Capital											
6								Interest on Insurance			879	6
7								Amortization of leasehold rights			67,021	7
8												8
9	TOTAL Facility Related				$7,672.00		$ 559,858	$ 433,504			$ 101,148	9
	B. Non-Facility Related*											
10								DSI Partners L.L.C.			6,828	10
11								Allocated from Management Company			2,200	11
12								Miscellaneous Interest Expense			20,349	12
13								Offset Interest Income			(13)	13
14	TOTAL Non-Facility Related						$	$			$ 29,364	14
15	TOTALS (line 9+line14)						$ 559,858	$ 433,504			$ 130,512	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.		$ 12,089	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 12,371	2
3. Under or (over) accrual (line 2 minus line 1).		$ 282	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 12,371	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	Rounding	$ (1)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 12,652	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	13,891	8
	1997	12,735	9
	1998	12,063	10
	1999	12,089	11
	2000	12,371	12

Real estate accrual is based on 100% of prior year's tax bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lynncrest Manor of Auburn COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0041459

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	34-10-205-020-1	Nursing Facility	$ 12,371.00	$ 12,371.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 12,371.00	$ 12,371.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,312 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign			1996	750	75	10	75		406	9
10	Sign			1996	961	96	10	96		513	10
11	Boiler Repair			1998	3,660	244	15	244		976	11
12	Door			1999	1,793	120	15	120		330	12
13	Carpeting			1999	667	67	10	67		162	13
14	Renovation of South Wing			1999	2,496	166	15	166		374	14
15	Boiler Repair			2000	730	49	15	49		85	15
16	Carpeting			2000	1,617	108	15	108		216	16
17	Water Heater			2000	1,278	85	15	85		105	17
18	Water Heater			2000	3,328	333	10	333		666	18
19	Concrete Work			2001	1,720	57	15	57		57	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 19,000	$ 1,400		$ 1,400	$	$ 3,890	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 35,517	$ 5,096	$ 5,096	$	5-10	$ 16,315	71
72	Current Year Purchases	9,397	186	186		5-10	186	72
73	Fully Depreciated Assets							73
74	Allocated from Management Company			388	388			74
75	TOTALS	$ 44,914	$ 5,282	$ 5,670	$ 388		$ 16,501	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 63,914	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 6,682	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 7,070	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 388	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 20,391	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Ellsworth F. O'Sullivan

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1966	70	12/15/80	$ 197,952	25	0	3
4	Additions							4
5								5
6	Allocated from Management Company				2,307			6
7	TOTAL		70		$ 200,259 **			7

8. List separately any amortization of lease expense included on page 4, line 34. None
This amount was calculated by dividing the total amount to be amortized by the length of the lease n/a . n/a

9. Option to Buy: [ ] YES [X] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning 12/15/80
Ending 12/31/05

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$ 197,952
13.	12/31/2003	$ 197,952
14.	12/31/2004	$ 197,952

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 3,790 Description: Office Copier $1933; Postage Machine $642; Allocated from Management Company $1215
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C3	hrs	$	114	$ 7,395	$	114	$ 7,395	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		45	3,450		45	3,450	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C3	hrs		1,098	71,393		1,098	71,393	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				8,151		8,151	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16A					2,005			2,005	13
14	TOTAL			$	1,257	$ 84,243	$ 8,151	1,257	$ 92,394	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lynncrest Manor of Auburn
Provider #0041459
12/31/2001

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Outside Practioner Cost	Outside Practioner Supplies
Laboratory	L39, C3		617	
X-Ray	L39, C3		105	
Urological	L39, C3		30	
Enteral	L39, C3		1,253	
Total			2,005	0

See Accountants' Compilation Report

STATE OF ILLINOIS

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (11,885)	$ (11,885)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,544)	125,327	125,327	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,930	28,930	6
7	Other Prepaid Expenses	9,296	9,296	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related Parties	933,522	933,522	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,085,190	$ 1,085,190	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	19,000	19,000	15
16	Equipment, at Historical Cost	44,914	44,914	16
17	Accumulated Depreciation (book methods)	(20,391)	(20,391)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Leasehold Rights	268,085	268,085	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 311,608	$ 311,608	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,396,798	$ 1,396,798	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 243,084	$ 243,084	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,494	57,494	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,061	4,061	31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,371	12,371	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	83,778	83,778	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 400,788	$ 400,788	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	26,590	26,590	39
40	Mortgage Payable	406,914	406,914	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 433,504	$ 433,504	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 834,292	$ 834,292	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 562,506	$ 562,506	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,396,798	$ 1,396,798	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 532,125	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 532,124	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	30,382	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 30,382	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 562,506	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,929,368	1
2	Discounts and Allowances for all Levels	(19,469)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,909,899	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	78,155	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 78,155	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	625	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,581	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	12,248	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,004	19
20	Radiology and X-Ray		20
21	Other Medical Services	44,896	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 62,354	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine Income	1,032	28
28a	Miscellaneous Income	2,341	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,373	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,053,794	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	382,348	31
32	Health Care	812,823	32
33	General Administration	415,017	33
	B. Capital Expense		
34	Ownership	348,186	34
	C. Ancillary Expense		
35	Special Cost Centers	26,713	35
36	Provider Participation Fee	38,325	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,023,412	40
41	**Income before Income Taxes (line 30 minus line 40)****	30,382	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 30,382	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity files as part of a combined cash basis tax return.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 40,048	$ 19.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,726	6,330	101,613	16.05	3
4	Licensed Practical Nurses	10,671	12,096	150,691	12.46	4
5	Nurse Aides & Orderlies	31,867	33,359	276,198	8.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,857	1,945	22,379	11.51	8
9	Activity Director					9
10	Activity Assistants	3,218	3,482	28,397	8.16	10
11	Social Service Workers	1,753	1,851	12,951	7.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,484	11,979	91,467	7.64	15
16	Dishwashers					16
17	Maintenance Workers	3,384	3,688	32,064	8.69	17
18	Housekeepers	6,249	6,658	41,903	6.29	18
19	Laundry	3,052	3,300	24,174	7.33	19
20	Administrator	2,080	2,080	48,949	23.53	20
21	Assistant Administrator					21
22	Other Administrative	359	381	15,068	39.55	22
23	Office Manager					23
24	Clerical	6,112	6,238	83,306	13.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,810	2,966	19,335	6.52	31
32	Other Health Ca Care Plan Coordin	1,848	2,020	27,099	13.42	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	94,550	100,453	$ 1,015,642 *	$ 10.11	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	122	$ 6,430	L1, C3	35
36	Medical Director	monthly	6,000	L9, C3	36
37	Medical Records Consultant	16	416	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	165	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	1,906	L11, C3	44
45	Social Service Consultant	38	1,905	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	214	$ 16,822		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	124	3,490	L10, C3	51
52	Nurse Aides	80	1,388	L10, C3	52
53	TOTAL (lines 50 - 52)	204	$ 4,878		53

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Larry Trigg	Administrator	0%	$ 48,949
Lester Robertson	Administrative	15%	15,068
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,017

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 15,806
TOTAL (agree to Schedule V, line 17, col. 3)	$ 15,806
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Consulting	$ 709
ADP	Payroll Service	4,342
Therapeak	Computer Services	1,020
AIMS	Computer Services	2,506
NCS Lease	Computer Services	2,845
Motion Interest & Networking	Computer Services	100
Dish Network	Computer Services	385
AM&G	Accounting Fees	9,125
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 21,032

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,206
Unemployment Compensation Insurance	8,079
FICA Taxes	73,356
Employee Health Insurance	30,869
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	516
Allocated from Management Company	4,843
TOTAL (agree to Schedule V, line 22, col.8)	$ 148,869

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
n/a		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,593
Health Care Worker Background Check	
(Indicate # of checks performed 48)	336
Illinois Health Care Association	3,697
Misc. License, Dues, & Subscriptions	410
Allocated from Management Company	55
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,291

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	287
Seminar Expense	1,643
Allocated from Management Company	1,078
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,008

* Attach copy of IMRF notifications

**See instructions.

Facility Name	**Lynncrest Manor of Auburn**
PROVIDER #	**0041459**
Period Ending	**12/31/01**

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	21,032
Allocated from Management Company	1,582
Total (agree to Schedule V, line 19, column 8)	22,614

See Accountants' Compilation Report

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Auburn # 0041459 Report Period Beginning: 1/1/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $3,697**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,209** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **38,325**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,581**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **6**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **n/a** If no, please explain. **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	91,467	7,111	6,430	105,008	0	105,008	0	105,008
2. Food P	0	90,240	0	90,240	0	90,240	-4,613	85,627
3. Housek	41,903	6,604	0	48,507	0	48,507	0	48,507
4. Laundry	24,174	6,192	0	30,366	0	30,366	0	30,366
5. Heat ar	0	0	58,261	58,261	0	58,261	34	58,295
6. Mainter	32,064	0	17,902	49,966	0	49,966	241	50,207
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	189,608	110,147	82,593	382,348	0	382,348	-4,338	378,010
9. Medical	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursin	637,363	33,694	5,459	676,516	0	676,516	0	676,516
10a. Thera	0	0	82,238	82,238	0	82,238	0	82,238
11. Activiti	28,397	2,781	1,906	33,084	0	33,084	0	33,084
12. Social	12,951	0	1,905	14,856	0	14,856	0	14,856
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	129	129	0	129	0	129
15. Other	0	0	0	0	0	0	0	0
16. Total H	678,711	36,475	97,637	812,823	0	812,823	0	812,823
17. Admin	64,017	0	15,806	79,823	0	79,823	-15,806	64,017
18. Directo	0	0	0	0	0	0	0	0
19. Profes	0	0	21,032	21,032	0	21,032	1,582	22,614
20. Fees,	0	0	7,236	7,236	0	7,236	55	7,291
21. Clerica	83,306	26,263	18,847	128,416	0	128,416	5,313	133,729
22. Emplo	0	0	144,026	144,026	0	144,026	4,843	148,869
23. Inserv	0	0	0	0	0	0	502	502
24. Travel	0	0	1,930	1,930	0	1,930	1,078	3,008
25. Other	0	0	2,115	2,115	0	2,115	0	2,115
26. Insura	0	0	30,439	30,439	0	30,439	61	30,500
27. Other	0	0	0	0	0	0	0	0
28. Total (	147,323	26,263	241,431	415,017	0	415,017	-2,372	412,645
29. Total (	1,015,642	172,885	421,661	1,610,188	0	1,610,188	-6,710	1,603,478
30. Depre	0	0	6,682	6,682	0	6,682	388	7,070
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	128,325	128,325	0	128,325	2,187	130,512
33. Real E	0	0	12,652	12,652	0	12,652	0	12,652
34. Rent -	0	0	197,952	197,952	0	197,952	2,307	200,259
35. Rent -	0	0	2,575	2,575	0	2,575	1,215	3,790
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	348,186	348,186	0	348,186	6,097	354,283
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	8,151	2,005	10,156	0	10,156	0	10,156
40. Barber	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	38,325	38,325	0	38,325	0	38,325
43. Other	0	0	16,557	16,557	0	16,557	-16,557	0
44. Total S	0	8,151	56,887	65,038	0	65,038	-16,557	48,481
45. Grand	1,015,642	181,036	826,734	2,023,412	0	2,023,412	-17,170	2,006,242

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	198,115	198,115
2. Cash - F	0	0
3. Account	125,327	125,327
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	28,930	28,930
7. Other Pr	9,296	9,296
8. Account	0	0
9. Other (s	933,522	933,522
10. Total c	1,295,190	1,295,190
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	0
14. Buildin	0	0
15. Leasel	19,000	19,000
16. Equipn	44,914	44,914
17. Accum	-20,391	-20,391
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other I	0	0
23. other (s	268,085	268,085
24. Total L	311,608	311,608
25. Total A	1,606,798	1,606,798
CURRENT LIABILITIES		
26. Accour	243,084	243,084
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	57,494	57,494
31. Accrue	4,061	4,061
32. Accrue	12,371	12,371
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other C	293,778	293,778
37. Other C	0	0
38. Total C	610,788	610,788
LONG TERM LIABILITES		
39.Long-Te	26,590	26,590
40.Mortgag	406,914	406,914
41.Bonds P	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	433,504	433,504
46.Total Li	1,044,292	1,044,292
47.Total Eq	562,506	562,506
48.Total Li	1,606,798	1,606,798

		Balance per Medicaid Trial Balance
1.	Gross F	1,929,368
2.	Discour	-19,469
	Subtota	1,909,899
4.	Day Ca	0
5.	Other C	0
6.	Therapy	78,155
7.	Oxygen	0
	Subtota	78,155
9.	Paymer	0
10.	Other	0
11.	Nurses	625
12.	Gift an	0
13.	Barber	0
14.	Non-P	3,581
15.	Teleph	0
16.	Rental	0
17.	Sale o	12,248
18.	Sale o	0
19.	Labora	1,004
20.	Radiol	0
21.	Other	44,896
22.	Laund	0
	Subtot	62,354
24.	Contril	0
25.	Interes	13
	Subtot	13
27.	Other	3,373
28.	Other	0
	Subtot	3,373
30.	Total F	2,053,794
31.	Gener	382,348
32.	Health	812,823
33.	Gener	415,017
34.	Owner	348,186
35.	Specia	26,713
35.	Provid	38,325
37.	Other	0
40.	Total E	2,023,412
41.	Incom	30,382
42.	Incom	0
43.	Net In	30,382

Page

Attachment of Real Estate Bill and fill out form

P12 does not show totals, it carries to P12a, therefore P12a must always be attached

The bottom right side of page under **, you must write in any comments

RECONCILIATION REPORT **Lynncrest Manor of Aub** **03:20 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-17,170	equal to	-17,170	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	130,512	equal to	130,512	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	12,652	equal to	12,652	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	7,070	equal to	7,070	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	200,259	equal to	200,259	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	3,790	equal to	3,790	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	82,238	equal to	82,238	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	8,151	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	382,348	equal to	382,348	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	812,823	equal to	812,823	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	415,017	equal to	415,017	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	348,186	equal to	348,186	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	26,713	equal to	26,713	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	38,325	equal to	38,325	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	587,885	equal to	637,363	-49,478	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	28,397	equal to	28,397	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	12,951	equal to	12,951	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	91,467	equal to	91,467	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	32,064	equal to	32,064	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	41,903	equal to	41,903	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	24,174	equal to	24,174	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	64,017	equal to	64,017	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	83,306	equal to	83,306	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,015,642	equal to	1,015,642	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	6,430	< or = to	6,430	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	5,459	< or = to	5,459	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,906	< or = to	1,906	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,905	< or = to	1,905	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	64,017	equal to	64,017	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	15,806	equal to	15,806	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	21,032	equal to	21,032	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	148,869	equal to	148,869	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	7,291	equal to	7,291	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,008	equal to	3,008	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	38,325	equal to	38,325	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	4,843	-4,843	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	640	equal to	640	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	4,013	equal to	4,013	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	433,504	equal to	433,504	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	12,371	equal to	12,371	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	0	equal to		0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	19,000	equal to	19,000	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	44,914	equal to	44,914	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	20,391	equal to	20,391	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	562,506	equal to	562,506	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	30,382	equal to	30,382	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,396,798	equal to	1,396,798	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1